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Nos. 96-1377 & 96-1526

In The

Supreme Court of the United States

October Term, 1996

AETNA HEALTH PLANS OF CALIFORNIA, INC., *et al.*,

Petitioners,

-and-

INLAND HEALTHCARE GROUP/ARROWWEST PHYSICIANS ASSOCIATION,

Petitioner,

vs.

WILLIAM ARDARY, *et al.*,

Respondents.

On Petitions for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether a state law tort action seeking wrongful death damages based on negligence and misrepresentation — but not seeking payment of Medicare benefits — is preempted by the federal Medicare Act's administrative remedies requirements.

TABLE OF CONTENTS

	Page
Question Presented	i
Table of Contents	ii
Table of Citations	v
Statement of the Case	1
A. Summary of Material Facts	1
B. Summary of Proceedings	3
Summary of Reasons for Denying Certiorari	4
A. The factual circumstances in this action are unique and do not implicate the issues raised by petitioner.	4
1. Petitioners misrepresent the nature of the issue presented.	4
2. Petitioners misrepresent the respondents' standing.	5
3. Respondents have not "admitted" or "conceded" that their action is "predicated" on the denial of Medicare benefits such that the wrongful death claims are "inextricably intertwined" with the benefit determination.	6

Contents

		Page
B.	There is no conflict among the circuits.	7
C.	This action does not raise important questions of public policy requiring this Court to protect Medicare HMOs in the same way ERISA fiduciaries are protected — because Congress did not intend to protect Medicare HMOs in the same way.	7
D.	The Ninth Circuit appropriately decided the issue and, even if it did not, an erroneous decision is not a proper basis for certiorari.	8
Reasons for Denying the Writ		9
I.	Standard For Granting Writ Of Certiorari	9
II.	Because the facts in this case include allegations of fraud, thereby creating a potential that the benefits sought were in excess of those mandated by Medicare, review is not warranted.	10
III.	Petitioners have admitted that there is no conflict among the circuits on the issue presented.	12
IV.	Since the Medicare administrative review provisions are in no way analogous to those of ERISA, and since petitioners cannot demonstrate that Medicare HMOs are entitled to the same broad protections as are ERISA fiduciaries, petitioners' claim of importance of the issue presented rings hollow.	14

Contents

Page

V. Even if the factual and legal context were different, certiorari would be inappropriate because the Ninth Circuit's decision was correct. 18

A. The foundational question of whether the "arising under" provision of 42 U.S.C. § 405(h) even applies to Aetna in its role as an HMO under § 1395mm has never been addressed by petitioners. 18

B. The claims asserted in this case cannot logically or rationally "arise under" Medicare because respondents have no standing to invoke the administrative review process and both the standing and the substantive basis for the damages claimed arise solely under state law. 20

C. Nor are the claims "inextricably intertwined" with the Medicare determination. 22

Conclusion 27

TABLE OF CITATIONS

Cases Cited:

American Federation of Home Health Agencies, Inc. v. Heckler, 754 F.2d 896 (11th Cir. 1984) 24

Bodimetric Health Services, Inc. v. Aetna Life & Casualty, 903 F.2d 480 (7th Cir. 1990), *cert. denied,* 498 U.S. 1012 (1990) 12, 13, 19, 20, 24

Contents

	Page
Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667, 106 S. Ct. 2133 (1986)	15
Davis v. United States, 417 U.S. 333 (1974)	9
Hatcher v. Heckler, 772 F.2d 427 (8th Cir. 1985)	24
Heckler v. Ringer, 466 U.S. 602, 104 S. Ct. 2013, 80 L. Ed. 2d 622 (1984)	20, 23
Homewood Professional Care Center, Ltd. v. Heckler, 764 A.2d 1242 (7th Cir. 1985)	19
Hooker v. United States Dept. of Health & Human Services, 858 F.2d 525 (9th Cir. 1988)	25
Jimenez-Nieves v. United States, 682 F.2d 1 (1st Cir. 1982)	25, 26
Layne & Bowler Corp. v. Western Well Works, 261 U.S. 387 (1923)	9
Manakee Professional Medical Transfer Service, Inc. v. Shalala, 71 F.3d 574 (6th Cir. 1995)	24
Marin v. HEW, Health Care Financing, 769 F.2d 590 (9th Cir. 1985), *cert. denied*, 474 U.S. 1061 (1986)	24
Massachusetts Medical Soc. v. Dukakis, 815 F.2d 790 (1st Cir. 1927)	17
NLRB v. Pittsburgh S.S. Co., 340 U.S. 498 (1951)	9

Contents

Page

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S. Ct. 1549 (1987) 8

Rice v. Sioux City Memorial Park Cemetery, 349 U.S. 70 (1955) 9

Solorzano v. Superior Court (Family Health Plan, Inc.), 10 Cal. App. 4th 1135, 13 Cal. Rptr. 2d 161 (1991), *cert. denied*, 510 U.S. 814 (1993) 7, 8, 12, 20

Taylor v. United States, 493 U.S. 906 (1989) 9

Ticor Title Ins. Co. v. Brown, __ U.S. __ , 114 S. Ct. 1359 (1994) 8

Weinberger v. Salfi, 422 U.S. 749 (1975) 23

Wisniewski v. United States, 353 U.S. 901 (1957) 9

Statutes Cited:

5 U.S.C. § 8902(m)(1) 14, 15

29 U.S.C. § 1001, *et seq.* 7

29 U.S.C. § 1144(a). 8, 15

42 U.S.C. § 405(g). 15

42 U.S.C. § 405(h). 18, 20, 25, 26

42 U.S.C. § 1395h 13, 20

Contents

	Page
42 U.S.C. § 1395mm	4, 8, 12, 13, 15, 18, 20, 21
42 U.S.C. § 1395mm(c)(2)(A)(ii)	6, 10
42 U.S.C. § 1395mm(c)(5)(B)	5, 21
42 U.S.C. § 1395oo	24
Rule Cited:	
Supreme Court Rule 10	9
Other Authorities Cited:	
42 C.F.R. § 417.604(a)(1)(ii)	10
42 C.F.R. § 417.604(b)(3)	10
42 C.F.R. § 417.604(c)	10
42 C.F.R. § 417.606(b)(2)	10
42 C.F.R. § 417.610	5, 21
California Code of Civil Procedure, § 377.60	22
13 James W. Moore, ed., *Moore's Federal Practice*, ¶ 810.21 (2d ed. 1995)	9
Witkin, *California Summary*, 9th Ed., Torts, Vol. 6, § 1197	22

Respondents William Ardary, Diane M. Houston, Kevin Ardary and William C. Ardary, M.D. respectfully submit this brief in opposition to the petitions for writ of certiorari seeking review of the decision of the United States Court of Appeals for the Ninth Circuit. The decision is reported at 98 F.3d 496 (1996) and is reprinted in both petitions at Appendix A.

STATEMENT OF THE CASE

The petitions seeking this Court's review misstate the issue, ignore pertinent facts, misrepresent the existence of a conflict among the circuits, and attempt to impose an unreasonably overbroad preemptive effect of the Medicare administrative review provisions. The petitions should be denied.

A. Summary of Material Facts

Respondents are the surving husband and children of Cynthia Ardary ("Cynthia"). Cynthia was a participant in and a beneficiary of the Aetna Senior Choice health maintenance organization plan. Petitioners' Appendices at 2a.[1]

Cynthia and her husband, respondent William Ardary, enrolled in Aetna's Senior Choice plan after attending a presentation made by petitioner Judith Hendrix in July, 1991 and sponsored by Aetna Health Plans of Southern California. *Id.* Cynthia and her husband resided in the geographically-isolated mountain community of Big Bear, California and, naturally, were concerned about the level of care which would be afforded to them as members of Aetna's health plan. *Id.* When the Ardarys questioned Aetna's representative, petitioner

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1. Both petitions included the Ninth Circuit's opinion in their respective appendices, with identical page numbering. All subsequent references will be to either petition's Appendix as "App."

Hendrix, about emergency care and the need for more sophisticated treatment than the tiny Bear Valley Community Hospital could provide, they were told by Hendrix that — should the need arise — Aetna would immediately authorize transfer to a larger facility such as Loma Linda University Medical Center. *Id.* As a result of the presentation by Aetna's marketing representive, the Ardarys enrolled in Aetna's Senior Choice plan on or about July 1, 1991. *Id.*

In the early morning hours of May 9, 1993, Cynthia suffered a mild heart attack and was taken to Bear Valley Community Hospital, a small hospital with no intensive care unit or cardiac care unit, which was essentially equipped to treat only minor illnesses and ski injuries. *Id.*

At the hospital, Cynthia, who was in serious condition, was attended by an Aetna physician. Because Bear Valley Community Hospital has no acute cardiac care facilities and was therefore ill-equipped to handle Cynthia Ardary's cardiac condition, Cynthia's attending physician determined that Cynthia needed to be air-lifted to Loma Linda University Medical Center ("Loma Linda") for treatment. *Id.*, at 2a-3a.

The doctor called petitioner Arrowwest, the administrator of the Aetna plan, as required by Aetna. An Arrowwest employee refused the request to transfer Cynthia Ardary to Loma Linda and reiterated that refusal on at least two more inquiries — even after Cynthia subsequently went into cardiac arrest. *Id.*, at 3a.

At or about 2 p.m. on May 9, 1993, Cynthia died as a result of acute myocardial infarction — which was the direct result of Aetna's unreasonable refusal to transfer her to Loma Linda where she could have received proper cardiac care. *Id.*

B. Summary of Proceedings

The complaint in this action was filed on January 25, 1994 in the Superior Court of the State of California, County of San Bernadino. *Id.* The complaint does ***not*** seek payment of the benefits under Aetna's plan. *Id.*, at 3a-4a. Rather the primary cause of action is for the wrongful death of respondents' wife and mother resulting from petitioners' negligent refusal to provide authorization for the air ambulance needed to transfer Cynthia and for the petitioners' fraud in inducing Cynthia to enroll in the Aetna plan with the assurance that such transfers ***would*** be provided, if needed.

After removing the action to the United States District Court, Central District of California, Aetna moved to dismiss the action on the grounds that, in the words of the Ninth Circuit, "the Ardarys' ***exclusive*** remedy for their action 'relating to' the denial of Medicare benefits was the administrative appeals process provided by HCFA." (*Id.*, at 4a; emphasis added.) After the District Court granted petitioners' motion to dismiss, respondents appealed. *Id.*, at 4a.

The Ninth Circuit reversed, holding that the Medicare administrative review process does not, and was never intended to, preempt all state-law based causes of action and does not, and was never intended to, thereby immunize "Medicare providers and their representatives . . . in their individual capacity for tortious acts in the context of the denial of Medicare benefits. The removal of the right to sue the private Medicare provider for its torts would result in an inequitable and substantial dilution of the rights of patients." *Id.*, at 12a-13a.

SUMMARY OF REASONS FOR DENYING CERTIORARI

When the hyperbole is weeded out of the petitions and their misstatements, misdirection and inaccuracies are corrected, it is apparent that petitioners have failed to meet their burden of demonstrating that there is a "compelling reason" for this Court to review the Ninth Circuit's decision:

A. The factual circumstances in this action are unique and do not implicate the issues raised by petitioners.

In order to adequately address the issue petitioners want this Court to decide — *i.e.*, the scope of Medicare's administrative review provisions in the context of benefits provided by a health maintenance organization ("HMO") under 42 U.S.C. § 1395mm, this Court needs a "pure" factual situation presenting a clear and unequivocal denial of a benefit mandated by Medicare as well as consequential damages which cannot be corrected or remediated by subsequent payment of the denied benefits. There must be a factual matrix which is unencumbered by allegations of fraud or claims of entitlement to benefits over and above those required by Medicare.

This is not that case.

1. Petitioners misrepresent the nature of the issue presented.

For example, the "Questions Presented" by the petitioners misconstrue the real issues in this case. Aetna's "Question Presented" misrepresents respondents' state law action as "seeking both Medicare benefits determinations and consequential damages." Aetna Petition, at i. That is an outright falsehood. Respondents are ***not*** seeking a Medicare benefits determination — a Medicare benefits determination at this point

will not return Cynthia Ardary to the bosom of her family. She will still be dead.

Similarly, Arrowwest's "Question Presented" casts the issue as one "challenging Medicare benefits determinations." Arrowwest Petition, at i. Again, the benefits determination is not, *per se,* at issue: Petitioners' negligence and fraud are.

2. Petitioners misrepresent the respondents' standing.

Arrowwest also misrepresents the Medicare statute by claiming that the Medicare Act "requires ***any individual*** dissatisfied with a Medicare benefits determination to exhaust the administrative remedies prescribed by the Medicare Act." Arrowwest petition, at i.

But even as demonstrated in Arrowwest's own petition, the administrative review provisions applicable to Medicare determinations ***by an HMO*** permit the administrative process to be invoked ***only*** by "[a] ***member*** enrolled with an eligible organization under this section who is dissatisfied by reason of ***his*** failure to receive any health service to which ***he*** is entitled . . . ." 42 U.S.C. § 1395mm(c)(5)(B); emphasis added. Thus, under the express language provided by Congress, the ***only*** person with standing to seek administrative review of the denial of the airlift transport ***was Cynthia Ardary*** or, under 42 C.F.R. § 417.610, her estate. Neither Cynthia Ardary nor her estate is a party to this action — again, because the action ***does not seek recovery of*** **Medicare benefits.** It seeks damages for **wrongful death.**

Since respondents have no standing to invoke the administrative review provisions of Medicare, and thus no *power* to do so, common sense dictates that they also have no *duty* to do so.

3. Respondents have not "admitted" or "conceded" that their action is "predicated" on the denial of Medicare benefits such that the wrongful death claims are "inextricably intertwined" with the benefit determination.

Aetna's repeated assertions that respondents "admitted" or "conceded" that their action is "predicated" on the denial of Medicare benefits does not warrant the conclusion drawn by Aetna that the claims are therefore "inextricably intertwined" with the benefit determination such that the administrative remedies provisions control.

Aetna's analysis overlooks one simple fact that — irrespective of the larger issue — renders review by this Court wholly inappropriate: Aetna specifically and expressly represented to Cynthia Ardary that, should the need arise, she would be airlifted out of Big Bear to Loma Linda University Medical Center. The representation was not limited. The representation was not conditional. The representation was not tied in any way, shape or form to entitlement to the transfer as ***a Medicare benefit.***

The Medicare statutes relating to HMOs require the HMO to provide benefits at least to the level Medicare allows. ***But they also allow the HMO to provide*** **more** ***benefits.*** 42 U.S.C. § 1395mm(c)(2)(A)(ii). Thus, the denial of benefits in this case is not necessarily predicated on a denial of ***Medicare*** benefits — it is predicated on a denial of ***promised*** benefits. Because Aetna promised Cynthia that a transfer would be provided if she needed it — without conditioning that promise on compliance with Medicare — the claim is ***not*** "inextricably intertwined" with the Medicare statutes and the administrative review provisions are not implicated.

This unique factual context therefore does not warrant the expenditure of this Court's resources on a case which cannot accurately delineate the issue.

B. There is no conflict among the circuits.

Petitioners contend that review of the Ninth Circuit's decision is necessary because it conflicts with decisions from other circuits. That assertion of grounds for certiorari, however, directly conflicts with petitioners' other statement that "[t]he Ninth Circuit's decision is one of the first to deal with the preemption issue confronting a health maintenance organization which provides services to Medicare beneficiaries." Aetna petition, p. 20 and incorporated by reference into Arrowwest's Petition.

Indeed, petitioners are correct. There is not one other federal case which deals with Medicare's administrative review provisions ***as they apply to HMOs.*** There is only one state case which does so — *Solorzano v. Superior Court (Family Health Plan, Inc.),* 10 Cal. App. 4th 1135, 1148-1149, 13 Cal. Rptr. 2d 161, 169-170 (1991) — a California court of appeal decision in which this Court denied certiorari, 510 U.S. 814 (1993). Since this case is the only federal circuit court case addressing the issue, there obviously cannot be a conflict among the circuits.

C. This action does not raise important questions of public policy requiring this Court to protect Medicare HMOs in the same way ERISA fiduciaries are protected — because Congress did not intend to protect Medicare HMOs in the same way.

Petitioners' stated goal is to impose the same sweeping preemptive effect under the Medicare administrative review provisions for the protection of HMOs as exist under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.* Aetna Petition, at pp. 20-21. To that end, petitioners misrepresent that "both ERISA and the Medicare Act incorporate similar jurisdictional preemption provisions for

cases predicated on a benefit determination." Aetna Petition, at p. 21. The fundamental flaw in petitioners' argument, however, is the simple fact that ***Congress did not provide the same preemption language in both statutes.***

As this Court has repeatedly emphasized, ERISA's preemption language is extraordinarily broad, *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 107 S. Ct. 1549 (1987), and the provisions of ERISA "supersede ***any and all*** state laws insofar as they may now or hereafter **relate to** any employee benefit plan." (29 U.S.C. § 1144(a); emphasis added.) No such preemption language appears anywhere in the Medicare statutes. In fact, despite the amendment of certain portions of the Medicare statute to include specific preemption provisions, Congress has not included ***any*** specific preemption provision ***at all*** with respect to 42 U.S.C. § 1395mm — the provision applicable to health maintenance organizations providing benefits to Medicare beneficiaries. *Solorzano, supra,* 10 Cal. App. 4th at 1148-1149, 13 Cal. Rptr. 2d at 169-170 (1991). But that fact in no way impeded petitioners from inappropriately arguing as if it did.

D. The Ninth Circuit appropriately decided the issue and, even if it did not, an erroneous decision is not a proper basis for certiorari.

And last, but not least, the Ninth Circuit's decision and application of the relevant statutes and this Court's prior decisions was, in fact, correct. But even if the Ninth Circuit's analysis was erroneous, that is not a proper basis for a grant of certiorari given the absence of one of the other bases for justifying review. *Ticor Title Ins. Co. v. Brown,* __ U.S. __, __, 114 S. Ct. 1359, 1362 (1994) (certiorari will not be granted merely to correct an erroneous decision.) Since, as noted above, the other assertable grounds for justifying review do not exist in this case, the petitions should be denied.

REASONS FOR DENYING THE WRIT

I.

STANDARD FOR GRANTING WRIT OF CERTIORARI

The rules of this Court state that a petition for a writ of certiorari "will be granted only for compelling reasons." Sup. Ct. R. 10. In general, certiorari will be denied if the case involves circumstances or issues which are not likely to be repeated, *see Rice v. Sioux City Memorial Park Cemetery*, 349 U.S. 70, 74 (1955) (noting that the Court reviews issues that are "beyond the academic or the episodic"); 13 James W. Moore, ed., *Moore's Federal Practice*, ¶ 810.21 at SC 10-23 (2d ed. 1995) (stating that the Court will not be inclined to review "an issue that is unlikely to recur" or which "results from a unique factual situation"), or if "the asserted error consists of . . . the misapplication of a properly stated rule of law." Sup. Ct. R. 10. Moreover, certiorari will be granted "only 'in cases involving principles the settlement of which is of importance to the public, as distinguished from that of the parties, and in cases where there is a real and embarrassing conflict of opinion and authority' " between the courts of appeals. *NLRB v. Pittsburgh S.S. Co.*, 340 U.S. 498, 502 (1951) (quoting *Layne & Bowler Corp. v. Western Well Works*, 261 U.S. 387, 393 (1923)). This Court has also refrained from resolving conflicts that arise between panels within the same circuit, on the grounds that such conflicts should be resolved by the court of appeals internally. *See, e.g., Taylor v. United States*, 493 U.S. 906, 907 (1989); *Davis v. United States*, 417 U.S. 333, 340 (1974); *Wisniewski v. United States*, 353 U.S. 901, 902 (1957).

II.

BECAUSE THE FACTS IN THIS CASE INCLUDE ALLEGATIONS OF FRAUD, THEREBY CREATING A POTENTIAL THAT THE BENEFITS SOUGHT WERE IN EXCESS OF THOSE MANDATED BY MEDICARE, REVIEW IS NOT WARRANTED.

The predicate for petitioners' request for review of the Ninth Circuit's decision in this case is the assertion that the Medicare administrative review provisions are the exclusive means of determining any right or claim related to a decision by a Medicare-contracted health maintenance organization. But this case does not present that question unencumbered by other circumstances. As the Ninth Circuit noted in framing the issue to be decided by it, the question is whether the exclusive administrative review provisions of the Medicare Act "apply to preclude the heirs of a deceased Medicare beneficiary from bringing state law claims for wrongful death against a private Medicare provider when those claims do not seek recovery of Medicare benefits but instead seek compensatory and punitive damages on the grounds that the provider both improperly denied emergency medical services ***and misrepresented its managed care plan to the beneficiary?"*** App., at 7a-8a; emphasis added.

As noted above, the Medicare Act mandates the minimum level of benefits HMOs must provide to their members. But 42 U.S.C. § 1395mm(c)(2)(A)(ii) allows the HMO to provide ***additional*** benefits over and above the mandated minimum. And 42 C.F.R. §§ 417.604(b)(3) and (c) specify that such supplemental benefits ***are not subject to the appeal procedures*** which Aetna is seeking to impose. *See also,* 42 C.F.R. § 417.606(b)(2) (denials regarding supplemental benefits are not "organizational determinations" for purposes of administrative review requirements [42 C.F.R. § 417.604 (a)(1)(ii)]).

Thus, the denial of the request for authorization for the airlift is ***not*** subject to the Medicare administrative review provisions if it falls within the ambit of a "supplemental" benefit. Inherent to the fraud allegations of the complaint is the conclusion that the airlift benefits were promised to Cynthia irrespective of and apart from any coverage Medicare would provide. By making those representations, Aetna personally assumed a duty to provide the airlift benefits — and thereby took the benefits outside the Medicare Act requirements.

Petitioners provided to this Court neither facts nor law demonstrating that the airlift was a Medicare-defined benefit in the first instance. Nor have respondents "conceded" or "admitted" that it was. The portion of the respondents' brief quoted by the Ninth Circuit — and ***misquoted*** by petitioners — does not "admit" that the entire action is "predicated" on the denial of ***Medicare*** benefits. Rather, the statement relied on by the Ninth Circuit only states that " 'the wrongful death action is predicated on the allegation that ***the*** benefits were, in fact, owed and were, in fact, wrongfully denied.' " (App., at 4a, n. 4; emphasis added.) Since petitioners have not shown that "***the*** benefits" owed and wrongfully denied were ***Medicare*** benefits, rather than supplemental or additional benefits owed under the fraud cause of action — and have concomitantly failed to show that the Medicare administrative review process was even triggered — petitioners have also failed to demonstrate a basis for review by this Court.

III.

PETITIONERS HAVE ADMITTED THAT THERE IS NO CONFLICT AMONG THE CIRCUITS ON THE ISSUE PRESENTED.

To support their claim that grounds for this Court's review exist, petitioners argue vociferously that the Ninth Circuit's rationale in this case creates a conflict among the circuits because, petitioners assert, it misapplies the "arising under" standard for determining whether Medicare review provisions apply based on this Court's past decisions and the rationale in the Seventh Circuit's decision in *Bodimetric Health Services, Inc. v. Aetna Life & Casualty,* 903 F.2d 480 (7th Cir. 1990), *cert. denied,* 498 U.S. 1012 (1990). Aetna Petition, p. 13. But petitioners are also forced to concede later in their petitions that ***no other case has decided the issue presented here:***

> The Ninth Circuit's decision is one of the first to deal with the preemption issue confronting a health maintenance organization which provides services to Medicare beneficiaries.

Aetna Petition, at p. 20.

Similarly, the Ninth Circuit itself noted the dearth of cases dealing with the interplay between the Medicare review statutes and 42 U.S.C. § 1395mm, the section of the Medicare Act dealing with HMOs. App., at 8a, n. 8. In fact, an examination of the annotations to § 1395mm reveals ***no*** other federal case regarding this issue and discloses only one state case — *Solorzano.* And although the *Solorzano* court conducted an extensive and thorough analysis of the preemption issue presented by the Medicare Act's administrative remedy

provisions, it did so in the context of allegations of fraudulent marketing practices, not wrongful claim determinations.

Despite the petitioners' assertion that the *Bodimetric* case presents a "direct and apparent" conflict among the circuits, Aetna Petition, at p. 13, the unvarnished truth is that it does not. That is because *Bodimetric* did not involve an HMO and *Bodimetric* was not decided under § 1395mm.

In *Bodimetric,* Aetna played a role entirely different from that at issue in this case. In *Bodimetric,* Aetna was a Medicare fiscal intermediary as set forth in 42 U.S.C. § 1395h which, on behalf of the Medicare administration, determined benefits to be paid to certain providers. Thus, its role in that case was as a representative of the federal government in the determination of what benefits would be approved for payment by Medicare. In this case, Aetna was an HMO regulated under 42 U.S.C. § 1395mm and was itself the medical care provider.

Also in *Bodimetric,* the medical care provider plaintiff was, in fact, seeking recovery of Medicare benefits which were alleged to have been wrongfully withheld. As repeatedly noted by the Ninth Circuit in its decision in this case, respondents do not seek reimbursement for Medicare-covered expenses for the simple reason that no Medicare covered expenditures were made.

Since *Bodimetric* did not deal with an ***HMO's*** denial of benefits, since *Bodimetric* did not arise under § 1395mm and since *Bodimetric* did not involve a claim seeking anything other than Medicare benefits, there is, in point of fact, no conflict — direct or otherwise — between the circuits because the Ninth Circuit is the only federal court to have addressed the question presented.

IV.

SINCE THE MEDICARE ADMINISTRATIVE REVIEW PROVISIONS ARE IN NO WAY ANALOGOUS TO THOSE OF ERISA, AND SINCE PETITIONERS CANNOT DEMONSTRATE THAT MEDICARE HMOs ARE ENTITLED TO THE SAME BROAD PROTECTIONS AS ARE ERISA FIDUCIARIES, PETITIONERS' CLAIM OF IMPORTANCE OF THE ISSUE PRESENTED RINGS HOLLOW.

Petitioners ring down a forecast of doom and destruction for Medicare HMOs if the Ninth Circuit's decision is not reviewed and reversed and petitioners thereby try to create an issue of importance warranting this Court's intervention. But the reports of the death of the Medicare HMO industry are greatly exaggerated. And even if all of Aetna's fears came to pass, that is a consequence not of the Ninth Circuit's decision but of Congress's drafting of the Medicare statutes as they relate to HMOs.

Petitioners try desperately to analogize the Medicare review provisions to those of ERISA. But that analogy is not merely false, it is not even credible. For example, compare the preemption language of ERISA, the Federal Employee Hospital Benefits ("FEHBA"), 5 U.S.C. § 8902(m)(1), and Medicare:

ERISA	FEHBA	MEDICARE
ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).	FEHBA "shall supersede and preempt any State or local law . . . to the extent inconsistent with such contractual provisions." 5 U.S.C. § 8902 (m)(1).	Under Medicare, "[a]ny individual, after any final decision of the Commissioner of Social Security . . . may obtain review of such decision by a civil action. . . . The court shall have the power to enter . . . a judgment affirming, modifying, or reversing the decision . . ." 42 U.S.C. § 405(g).

To compare the complete preemption of "any and all State" laws under ERISA and FEHBA to the administrative review provisions of Medicare is overreaching of the worst sort. Nowhere in the Social Security Act or in the Medicare Act, as it applies to Medicare HMOs under § 1395mm, did Congress even implicitly attempt to preclude tort actions based on a Medicare HMO's wrongful conduct. As quoted by the Ninth Circuit from this Court's decision in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 680, 106 S. Ct. 2133, 2141 (1986):

> Indeed, the "legislative history of both the statute establishing the Medicare program and the 1972 amendments thereto provides specific evidence of Congress' intent to foreclose review only of 'amount determinations' — i.e., those 'quite minor

> matters,' 118 Cong. Rec. 33992 (1972) (remarks of Sen. Bennett), remitted finally and exclusively to adjudication by private insurance carriers in a 'fair hearing.' "

App., at p. 12a.

The upshot of that was cogently articulated by the Ninth Circuit in its decision in this case:

> We find nothing in the legislative history [of the Medicare Act] to suggest that the Act was designed to abolish all state remedies which might exist against a private Medicare provider for torts committed during its administration of Medicare benefits pursuant to a contract with HCFA.

App., at p. 12a.

As has been widely recognized, ERISA's preemption provision has erected an impenetrable wall of immunity around insurers and HMOs in dealing with employment-related benefits decisions which has caused, and continues to cause, much chagrin in Congress. But even if Congress did intend the immunity protections derived from ERISA's preemption language in the employment context, there is no justification for expanding that immunity into areas where no such intent was even hinted at, let alone expressed. Congress obviously knows how to enact a broad preemption provision when it intends to — and did so in ERISA and FEHBA. But there is nothing in the language of the Medicare statutes, or in the congressional intent or the legislative history underlying them, that justifies foreclosure of the respondents' tort claims ***even if the action is one "arising under" the Medicare statutes.***

Additionally, one of the congressional purposes in enacting ERISA in the first instance was to protect employee pension and benefit funds from mismanagement and loss. In order to assure the ready availability of funds for the benefit of the employees, Congress used such broad preemptive language so as to provide a consistent and orderly administrative structure for ERISA fiduciaries. ***But a Medicare HMO is not an ERISA-type fiduciary. A Medicare HMO has no employee fund to administer. A Medicare HMO has no need of a consistent and orderly administrative structure.***

In contrast to the situation in ERISA — where one of the primary goals was a consistent regulatory framework in order to preserve the availability of plan funds — the Medicare Act's sole purpose is to assure that America's aged and disabled are provided with a minimum level of medical care. *Massachusetts Medical Soc. v. Dukakis,* 815 F.2d 790, 794 (1st Cir. 1987) (the basic purpose of the Medicare Act is "to insure adequate medical care for the elderly").

Obviously, imposing tort liability on an HMO which ***wrongfully*** refuses to authorize treatment or care to which the member is entitled under Medicare and/or the member's contract with the HMO will not discourage or hamper the HMO's vigilance in assuring that appropriate care is provided as required under Medicare. On the contrary, potential liability for such damages will encourage and enhance the HMO's appropriate and proper provision of promised benefits — and will assure that Congress' intent is fulfilled.

Indeed, petitioners' citation to statistics demonstrating the increasing numbers of senior Americans enrolling in Medicare HMO plans emphasizes the importance of ***not*** permitting Medicare HMOs to operate in a zone of absolute immunity. It is certainly understandable why Aetna and the other HMOs would

like to have the same immunity shield in the Medicare context as they do in the ERISA context. But since neither the language nor intent of ERISA is analogous to the language and intent of Medicare, petitioners' effort to create an "issue of importance" in order to entice this Court's interest by seeking to expand Medicare's administrative review provisions into a broad and sweeping preemption provision like that in ERISA is deceptive and dishonest.

V.

EVEN IF THE FACTUAL AND LEGAL CONTEXT WERE DIFFERENT, CERTIORARI WOULD BE INAPPROPRIATE BECAUSE THE NINTH CIRCUIT'S DECISION WAS CORRECT.

Over and above all the other reasons that certiorari is inappropriate in this case is the simple fact that the Ninth Circuit was right. Even assuming there were no fraud allegation, even assuming the airlift transport was covered under Medicare and not under any supplementary coverage, even assuming the damages claimed were "predicated" on a wrongful denial of Medicare benefits, the decision was right.

A. The foundational question of whether the "arising under" provision of 42 U.S.C. § 405(h) even applies to Aetna in its role as an HMO under § 1395mm has never been addressed by petitioners.

Petitioners' argument is grounded on the application of 42 U.S.C. § 405(h) which provides, in pertinent part, that "[n]o action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any ***claim arising under*** this subchapter." (Emphasis added.) The application of the "arising

under" language is the jumping-off point at which petitioners and the Ninth Circuit's respective analyses diverge.

But there is a foundational issue which was never raised or addressed by either petitioners or the Ninth Circuit — although it was argued by respondents. One distinction between this case and every other case referenced by both the Ninth Circuit and the petitioners is that all the cited cases were brought against the Secretary or an officer or employee of the government. But there is no case holding that an HMO is transmuted into "an officer or employee" of the government when it contracts with HCFA to become a provider of medical care services for Medicare enrollees.

And that situation is expressly distinct even from *Bodimetric*, the case so heavily relied on by Aetna. In *Bodimetric*, Aetna was a Medicare fiscal intermediary which, on behalf of the Medicare administration, determined benefits which were to be paid to certain providers. The plaintiff in *Bodimetric* was a home health care agency which provided home health care services to Medicare patients. Under Medicare, the Secretary of Labor was charged with the duty to determine and pay the claims by those providers. However, Medicare also allowed the Secretary to assign those obligations to entities known as "fiscal intermediaries."

> A fiscal intermediary is an entity that has contracted with the Secretary to determine for the Secretary whether services provided . . . are covered under the Medicare Act and the amount due the provider of services.

Homewood Professional Care Center, Ltd. v. Heckler, 764 F.2d 1242, 1244, n. 2 (7th Cir. 1985).

As determined in *Bodimetric,* the fiscal intermediary is an "officer or employee" of the Secretary and is protected from legal actions to the same extent as the Secretary under § 405(h). But there is no basis for concluding that an HMO under § 1395mm is the equivalent of a fiscal intermediary acting on behalf of the government under § 1395h. Rather the HMO in a case under § 1395mm is actually a ***medical provider*** — just like the ***plaintiff*** in *Bodimetric.* The only difference is that a Medicare HMO is paid a flat monthly rate rather than on a fee-for-service basis. *See Solorzano, supra,* 10 Cal. App. 4th at 1140, 13 Cal. Rptr. 2d 163-164. To extend § 405(h) to a Medicare HMO would insulate the HMO — and every other Medicare provider — from negligence liability even for medical malpractice — an inconceivable result.

B. The claims asserted in this case cannot logically or rationally "arise under" Medicare because respondents have no standing to invoke the administrative review process and both the standing and the substantive basis for the damages claimed arise solely under state law.

Even assuming the foundational determination that a Medicare HMO is entitled to invoke 42 U.S.C. § 405(h), the Ninth Circuit's analysis of whether the respondents' claims "arise under" that section was correct.

This Court's cases — cited by both petitioners and the Ninth Circuit — establish that for § 405(h) to apply, the claim must "arise under" the Medicare statutes in the first instance. In *Heckler v. Ringer,* 466 U.S. 602, 615, 104 S. Ct. 2013, 2021-2022, 80 L. Ed. 2d 622 (1984), this Court concluded that for an action to "arise under" Medicare the action must include "claims in which 'both the standing and the substantive basis for the presentation' of the claims" is the Medicare Act. None of those elements are present here.

First, the respondents have no standing to seek review under the Act. The ***specific*** administrative review provisions under § 1395mm — the part of the Act applicable to HMOs — allow the administrative process to be invoked ***only*** by "[a] ***member*** enrolled with an eligible organization under this section who is dissatisfied by reason of ***his*** failure to receive any health service to which ***he*** is entitled. . . ." 42 U.S.C. § 1395mm(c)(5)(B); emphasis added. Thus, under the express language provided by Congress, the ***only*** person with standing to seek administrative review of the denial of the airlift transport ***was Cynthia Ardary*** or, under 42 C.F.R. § 417.610, her estate. Neither Cynthia Ardary nor her estate is a party to this action — again, because the action ***does not seek recovery of Medicare benefits.*** It seeks damages for ***wrongful death.*** Since the respondents have no standing under the Act to even invoke the administrative review provisions, their claims cannot logically "arise under" the Act.

Second, the fact that respondents are seeking wrongful death damages is what provides the sole basis for the standing which ***does*** exist. As repeatedly emphasized by the Ninth Circuit, the respondents are not seeking Medicare ***benefits*** — again because retroactive approval of the airlift will do nothing to restore Cynthia Ardary to life and cannot compensate for the actual damages caused by her death. It would indeed be anomalous to hold that a wrongful death claim "arises under" the Medicare Act when, in fact, a determination that the Medicare benefits should have been paid will do nothing to compensate the parties for their losses.

In fact, respondents' action is predicated on their ***independent legal right*** to recover damages from one whose negligence causes the death of a spouse or parent. That legal right is not derivative of Cynthia Ardary's rights under the Aetna plan and does not "relate to" the benefits owed in the sense that term is used in the preemption context. That is because

California's wrongful death statute creates a *new cause of action* based on the heirs' own ***independent*** pecuniary injury suffered as the result of the loss of a relative. California Code of Civil Procedure, § 377.60; Witkin, *Cal. Summary*, 9th Ed., Torts, Vol. 6, § 1197. Petitioners therefore owed their own primary, independent duty of care to the ***heirs*** of Cynthia Ardary, separate and apart from their duty under the Senior Care plan to actually authorize payment of the benefits.

Thus, the respondents' standing is not dependent on the Medicare Act and, in turn, the substantive basis for their right of action arises under state law — *i.e.*, under California's wrongful death statute. That being the case, their claim does not "arise under" the Act. Since it does not "arise under" the Act, it is not subject to the administrative review provisions of the Act.

C. Nor are the claims "inextricably intertwined" with the Medicare determination.

Petitioners erroneously argue that, irrespective of the fact that no Medicare benefits are claimed, the wrongful death damages are "inextricably intertwined" with the Medicare determination and therefore mandate preemption. Petitioners do not explain, however, exactly how the Medicare administrative review procedures will provide standing to respondents to assert their claims. Nor do they explain how the Secretary, at the ultimate pinnacle of the review process, can award benefits which were never used and which can no longer be used. Nor do they explain how the Secretary can compensate Cynthia's husband and children for the loss of her care, comfort and society — the damages recoverable for her wrongful death.

The "inextricably intertwined" language used by this Court and the "arising under" provision used by Congress must be

applied rationally. If the administrative review process cannot compensate for the injuries done by a Medicare HMO either in its failure to provide needed care or in its negligent provision of needed care, the claim at issue is not "inextricably intertwined" with the Medicare-based decision because reversal of the Medicare-based decision cannot correct or compensate for the consequential injuries.

All of the cases cited by and relied on by petitioners related "at bottom" to an intent to recover the actual Medicare payments themselves and ***not one*** dealt with a claim seeking solely consequential damages from the failure to provide Medicare services needed by an enrollee:

- *Weinberger v. Salfi*, 422 U.S. 749, 760-761 (1975) involved a constitutional challenge to the portion of the Social Security Act limiting widow and orphan benefits. The widow in *Salfi* was not bringing the challenge out of the goodness of her heart. She was bringing the challenge in order to qualify for Social Security benefits. Moreover, there could be no recovery for consequential damages resulting from the denial of those benefits because any denial in compliance with the statutory mandate could not, by definition, be tortious.

- In *Heckler v. Ringer*, 466 U.S. 602, 605 (1984) Medicare beneficiaries sought declaratory and injunctive relief regarding denials of coverage for a particular surgical procedure. Though cast as a claim for equitable relief, the equitable relief sought would have had the practical effect of requiring Medicare to pay the benefits claimed for the procedure. Again, no consequential damages were claimed — only the benefits.

The court of appeals decisions from the other circuits cited by petitioners are all to the same effect:

- *Bodimetric* was an action brought by medical providers seeking payment for care provided to Medicare enrollees;

- *Manakee Professional Medical Transfer Service, Inc. v. Shalala*, 71 F.3d 574 (6th Cir. 1995) was a case brought by a medical provider (ambulance transportation) seeking retroactive Medicare payments;

- *Hatcher v. Heckler*, 772 F.2d 427 (8th Cir. 1985) involved an action seeking damages under Part B of the Medicare Act by claimants;

- *American Federation of Home Health Agencies, Inc. v. Heckler*, 754 F.2d 896 (11th Cir. 1984) was an action by Medicare providers challenging reimbursements provisions;

Petitioners' citation to two older Ninth Circuit cases as being in conflict with the decision in this case is similarly inapposite. In *Marin v. HEW, Health Care Financing*, 769 F.2d 590 (9th Cir. 1985), *cert. denied*, 474 U.S. 1061 (1986), the Ninth Circuit held that a provider's claim for financial damages resulting from the delayed payment of reimbursement owed to him was subsumed under 42 U.S.C. § 1395oo which sets forth a different review procedure for Medicare providers and which expressly provides interest on wrongfully delayed payments. Since no part of the Medicare statutes or the administrative review sections incorporated into them permit recovery by these respondents — who have no standing under the statutes — or permit recovery of the damages caused by petitioners' negligence, *Marin* is inapplicable.

Petitioners also rely on *Hooker v. United States Dept. of Health & Human Services*, 858 F.2d 525 (9th Cir. 1988), a wrongful death action brought against the Secretary, the Department and their employees for negligently terminating the Social Security benefits of the decedent, thus triggering his suicide. The problem with the application of *Hooker* to this case is the simple fact that the plaintiffs were suing the very parties § 405(h) forbids actions against: The Secretary, the government and their employees. None of those parties are defendants in this action.

Moreover, the *Hooker* court failed to distinguish the holding in *Jimenez-Nieves v. United States*, 682 F.2d 1 (1st Cir. 1982). In that case, the son of a Medicare recipient sued for consequential damages resulting from Social Security's negligent action in dishonoring checks issued to the recipient and cashed by the son for payment of the recipient's bills. The Administration dishonored the checks due to a keypunch error indicating that the recipient had died when, in fact, she had not. The court of appeals held that the action did not "arise under" § 405(h) as delineated in *Salfi* and noted:

> An action for damages based on a tort committed in the course of administering the Social Security Act does not arise "under" a "subchapter" that provides for the payment of social security benefits any more than a tort claim based on a negligently driven postal truck arises under the postal acts. . . .
>
> More importantly, however, to accept the Government's argument would imply that tort claims against the Government in general arise not only under the Federal Tort Claims Act and state law, but also under whatever statute the defendant agency happens to be

> administering. . . . Thus, the Government's argument, if accepted, would replace a reasonably uniform and clear system for handling tort suits against the government (embodied in the Tort Claims Act) with a hodgepodge of procedural requirements, drawn from a host of different statutes not necessarily drafted with tort suits in mind. In this case, for example, the "administrative hearing" procedures of § 405(g) are well suited to the decision of benefit claims. But they are anomalous if applied to tort claims. . . . We are aware of no reason why so totally different a system for resolving tort claims against the government should apply to claims that happen to grow out of administration of the Social Security Act. The Government offers us no evidence that such was the intent of Congress, here or elsewhere, nor does it explain how, or why, that result would be desirable. Thus, we find its "jurisdictional" argument without merit.

Jimenez-Nieves, 682 F.2d at 3.

That rationale applies with even greater force here since petitioners are neither the "Government" nor representatives of the "Government." Rather, they are Medicare ***providers*** whose negligent conduct is in no way even remotely intended to be protected by § 405(h).

And, unlike all the cases relied on by petitioners, this case does not seek reimbursement for payment of medical care which should have been provided by Medicare, nor does it seek direct or indirect payment of any Medicare benefits. Because this is

not an action which in any way, shape or form seeks the Medicare benefits themselves, the Ninth Circuit's decision was not only correct under this Court's rationale in the "arising under" decisions, it is the only logical one in the context of the issues here.

CONCLUSION

The petitions presented to this Court rely on misstatements of fact, misapplication of law and misdirection of analysis in order to achieve the goal of obtaining review of a correct decision. The petitioners' rhetoric and obduracy are understandable: They naturally long to escape from the consequences of their unreasonable and bad faith refusal to provide the airlift transfer they owed to Cynthia Ardary under their contract with her. But a defendant's desire to escape the consequences of its own wrongful conduct has never been a sufficient basis for invoking this Court's scrutiny and this case presents nothing — either factually or legally — warranting a change in that long-standing policy.

The petition for certiorari should be denied.

Respectfully submitted,

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